V. Provisions of the Final Rule

We are adopting the provisions of the proposed rule with the following revisions:

Section 409.43

We revised paragraph (c) to clarify that the request for anticipated payment for the initial percentage payment is not a Medicare claim under the Act and subject to the requirement that the physician sign the plan of care before the HHA bills for the initial percentage payment. The request for anticipated payment for the initial percentage episode payment may be based on verbal orders that are copied into the plan of care with the plan of care being immediately submitted to the physician. However, the requests for anticipated payments may be modified or withheld in order to protect Medicare program integrity. However, the final percentage payment is a claim subject to the current physician signature requirements. We revised current paragraph (c) governing physician signature of the plan of care. Specifically, paragraph (c)(1) of this section specifies, “If the physician signed plan of care is not

available, the request for anticipated payment of the initial percentage payment must be based on--

- A physician's verbal order that--
  - Is recorded in the plan of care;
  - Includes a description of the patient's condition and the services to be provided by the home health agency;
  - Includes an attestation (relating to the physician's orders and the date received) signed and dated by the registered nurse or qualified therapist (as defined in 42 CFR 484.4) responsible for furnishing or supervising the ordered service in the plan of care; and
  - Is copied into the plan of care and the plan of care is immediately submitted to the physician; or
- A referral prescribing detailed orders for the services to be provided that is signed and dated by a physician."

In paragraph (c)(2) of this section, we specify that "HCFA has the authority to reduce or disapprove requests for anticipated payments in situations when protecting Medicare program integrity warrants this action. Since the request for anticipated payment is based on verbal

orders as specified in paragraphs (c)(1)(i) and/or a prescribing referral as specified in (c)(1)(ii) of this section and is not a Medicare claim for purposes of the Act (although it is a “claim” for purposes of Federal, civil, criminal, and administrative law enforcement authorities, including but not limited to the Civil Monetary Penalties Law (as defined in 42 U.S.C. 1320a-7a (i) (2)), the Civil False Claims Act (as defined in 31 U.S.C. 3729(c)), and the Criminal False Claims Act (18 U.S.C. 287)), the request for anticipated payment will be canceled and recovered unless the claim is submitted within the greater of 60 days from the end of the episode or 60 days from the issuance of the request for anticipated payment.”

Paragraph (c)(3) of this section specifies that “The plan of care must be signed and dated--

! By a physician as described who meets the certification and recertification requirements of §424.22 of this chapter and;

! Before the claim for each episode for services is submitted for the final percentage payment.”

Paragraph (c)(4) of this section specifies that “Any changes in the plan must be signed and dated by a physician.”

Section 409.43

We revised the paragraph (e) of this section to clarify that the plan of care must be reviewed by the physician at least every 60 days or more frequently when there is a beneficiary elected transfer, significant change in condition, or discharge and return to the same HHA during the same 60-day episode.

We also made a conforming change in paragraph (f) of this section regarding the termination of the plan of care by replacing “62-day” with “60-day.” We amended this paragraph to specify that if specific services are not provided to the beneficiary at least once every 60-days, the plan of care is terminated unless the physician documents that the interval without this care is appropriate to the treatment of the beneficiary’s condition.

Sections 409.100(a)(2), 410.150(b)(19), and 411.15(q)

We revised the regulations at §§409.100(a)(2), 410.150(b)(19), and 411.15(q) to conform to the BBRA

revisions that eliminate DME from the consolidated billing requirements.

Section 413.64

We revised §413.1(h) to clarify that durable medical equipment and the covered osteoporosis drug as defined in section 1861(m) of the Act are not included in the HHA PPS rate.

We deleted §413.64(h)(2)(iv). This corresponds to our revision in the proposed rule to remove Part A and Part B home health services from §413.64(h)(1). PIP is eliminated for home health services upon implementation of PPS.

Section 424.22

We are not adopting proposed paragraph (a)(1)(v) that would have required the physician to certify the correct HHRG.

Section 484.1(a)

We amended this section by adding a new paragraph (3) to include the provision under the Act that provides the basis for establishing the new prospective payment system for home health services covered under Medicare.

Section 484.18

We revised the paragraph (b) to clarify that the plan of care must be reviewed by the physician at least every 60 days or more frequently when there is a beneficiary elected transfer, significant change in condition, or discharge and return to the same HHA during the same 60-day episode.

Section 484.55

We revised paragraph (d)(1) to specify that the update to the comprehensive assessment is required the last five days of every 60 days beginning with the start of care date unless there is an applicable payment adjustment. This clarification parallels the current OASIS requirements governing the timeframe of the update.

Section 484.202

We amended this section by removing the term “clinical model” from the list of definitions because we did not use the term in this subpart.

Section 484.205

We revised paragraph (a)(1) and (b) to clarify that the PPS payments are based on a predetermined rate for a home health service previously paid on a reasonable cost

basis and that the osteoporosis drug covered under the home health benefit is the only home health service listed in section 1861(m) of the Act that continues to be paid on a reasonable cost basis under PPS. The revised language will read, “The national 60-day episode payment represents payment in full for all costs associated with furnishing a home health service paid on a reasonable cost basis (except the osteoporosis drug listed in section 1861(m) of the Act as defined in section 1861(kk) of the Act) as of August 5, 1997....”

We also clarify in paragraph (b) that all payments under this system must be subject to a medical review adjustment reflecting beneficiary eligibility, medical necessity determinations, and the HHRG assignment.

We added paragraphs (b)(1) and (b)(2) that provides for the requirements governing the final split percentage payment approach. New paragraph (b)(1) governs the split percentage payment approach for initial episodes. The initial percentage payment for initial episodes is paid at 60 percent of the case-mix and wage adjusted 60 day episode rate. The residual final payment for initial episodes is paid at 40 percent of the case-mix and wage

adjusted 60 day episode rate. New paragraph (b)(2) governs the split percentage payment approach for subsequent episodes. The initial percentage payment for subsequent episodes is paid at 50 percent of the case-mix and wage adjusted 60 day episode rate. The residual final payment for subsequent episodes is paid at 50 percent of the case-mix and wage adjusted 60 day episode rate.

We revised paragraph (d) of this section to clarify that PEP adjustments do not apply in situations of transfer among HHAs of common ownership as defined in §424.22. Those situations would be considered services provided under arrangement on behalf of the originating HHA by the receiving HHA with the common ownership interest for the balance of the 60-day episode. The common ownership exception to the transfer PEP adjustment does not apply if the beneficiary moves to a different MSA or Non-MSA during the 60-day episode before the transfer to the receiving HHA. The transferring HHA in situations of transfers among HHAs of common ownership not only serves as a billing agent, but must also exercise professional responsibility over the arranged-

for services in order for services provided for under arrangements to be paid.

Section 484.215

We renamed the heading of section 484.215 to clarify that the calculation reflects the initial establishment of the PPS rates. Section 484.215 has been revised to read “Initial establishment of the calculation of the national 60-day episode payment.” We revised paragraph (d)(4) to reflect the amounts that are added to the nonstandardized episode amount for the OASIS adjustment for the one time implementation costs associated with assessment scheduling form changes and amounts for Part B therapies that could have been unbundled to Part B prior to PPS implementation.

Section 424.220

We revised §484.220 to specify that HCFA adjusts the national 60-day episode payment rate to account for geographic differences in wage levels using an appropriate wage index based on the site of the service for the beneficiary.

Section 484.225(c)

We revised paragraph (c) to reflect that for each of FYs 2002 and 2003 the rates are updated by the applicable home health market basket minus 1.1 percentage points.

Section 484.230

We revised the language in this section to reflect the higher per-visit amounts that will be used to calculate the LUPA payments. The amounts will be referred to as national per-visit amounts. We also clarified that the wage index are based on the site of service for the beneficiary.

Section 484.235

We revised paragraph (b) to reflect the use of billable visit dates as the defining points for the PEP adjustment. The following phrase will be added to the end of the sentence, “...based on the first billable visit date through and including the last billable visit date.”

Section 484.237

We revised paragraphs (b)(1) and (b)(2) governing the SCIC adjustment to reflect the use of billable visit dates to define the span of days used to calculate the

proportional payments both before and after a patient experiences a significant change in condition. In §§484.237(b)(1) and (b)(2) we inserted the phrase “(the first billable visit date through and including the last billable visit date)” after the phrase “span of days.”

Section 484.240

We revised paragraph (d) to reflect the higher per-visit amounts that will be used to calculate the imputed costs for each episode for outlier payment determination. The amounts are referred to as national per-visit amounts.

Section 484.245

We added new §484.245 that sets forth the processes involving accelerated payment requests by an HHA under PPS if there is a delay by the intermediary in making payment.